

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-034218

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUD

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8211** STATE FILE NUMBER

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4165 Westminster</b>
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>C.</b> Last <b>WEBSTER</b>		4. DATE OF DEATH Month <b>8</b> Day <b>10</b> Year <b>63</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/16/1919</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Yardman</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>43</b>
11. BIRTHPLACE (City and state or country) <b>Success, Arkansas</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Herman Webster</b>		13b. MOTHER'S MAIDEN NAME <b>Bertha Stevens</b>	14. NAME OF HUSBAND OR WIFE <b>Reda</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <b>Yes</b> <b>W. I. # 2</b>		17. INFORMANT Address <b>Reda Webster, 4165 Westminster</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute hepatic insufficiency</b> DUE TO (b) <b>alcoholic cirrhosis</b> DUE TO (c) <b>chronic alcoholism</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>587.1</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour: Month; Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>8/6/63</b> to <b>8/10/63</b> and last saw her/him alive on <b>8/10/63</b> Death occurred at <b>12:55 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Arthur P. Davis</i>		22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	22c. DATE SIGNED <b>8/10/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-10-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>	23d. LOCATION (City, town, or county) (State) <b>Corning, Arkansas.</b>
24. FUNERAL DIRECTOR <b>Albert H. Hoppe Inc., 4700 Washington,</b>		25. DATE RECD. BY LOCAL REG. <b>AUG 12 1963</b>	26. REGISTRAR'S SIGNATURE <i>Roan Smith, M.D.</i>

SHEIN

USE BLACK INK OR TYPEWRITER RIBBON

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Stanley H. Dixon

Licensed Embalmer No. 4193

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.

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